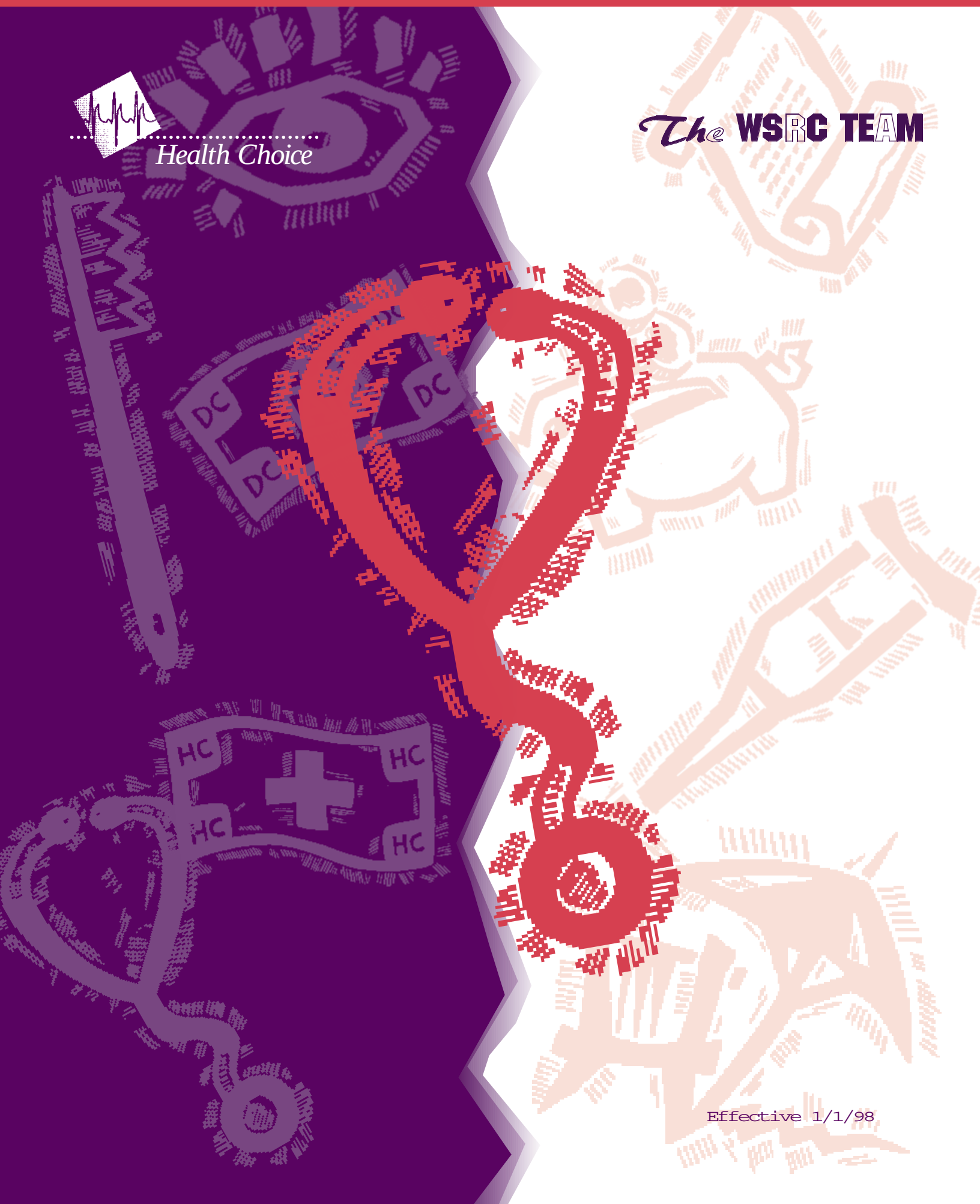
MEDICAL CARE

Health Choice

The WSRC TEAM



Effective 1/1/98

INTRODUCTION

The medical care benefits described in this Summary Plan Description are sponsored by Westinghouse Savannah River Company and Bechtel Savannah River, Incorporated (WSRC/BSRI), and administered by Westinghouse Savannah River Company (WSRC). Persons eligible to participate in the WSRC/BSRI Health Choice Medical Plan include those as described herein who are connected by employment with the WSRC Team. "The WSRC Team" includes Westinghouse Savannah River Company (WSRC), Bechtel Savannah River, Incorporated (BSRI), Babcock and Wilcox Savannah River Company (B&W) and British Nuclear Fuels, Limited, Savannah River Corporation (BNFL).

The WSRC/BSRI Health Choice Medical Plan is a self-insured multiple employer plan which uses funds from the U.S. government and contributions from Plan participants to pay the cost of claims and administrative expenses. Cost-sharing of medical benefits places the WSRC Team into a more competitive position with large employer business practices and enhances its ability to attract important missions at the Savannah River Site.

Under the WSRC/BSRI Health Choice Medical Plan, you have several medical options:

- Prime Choice,
- Standard Choice,
- Basic Choice,
- Blue Choice Health Maintenance Organization (HMO)*,
- No medical coverage.

All of the options are designed to protect you and your family from the high cost of medical treatment. Each offers a different level of protection. Prime and Standard Choice offer a higher level of benefits when you choose treatment through a network of doctors, hospitals and certain other providers, while offering you the option to use non-Network providers. Basic Choice requires you to pay a relatively high deductible before the plan will pay any benefits. Blue Choice HMO provides the highest level of coverage, but you must use HMO providers to have any non-emergency benefit coverage. You also have the option of electing no medical coverage.

* Blue Choice HMO is available only to full-service active employees.

This book provides details regarding your Health Choice Prime, Standard and Basic Choice medical coverage options. Information on Blue Choice HMO is provided in a separate Summary Plan Description prepared by HMO Georgia, Inc. Read this book carefully and refer to it whenever you have any questions about your Prime, Standard or Basic Choice medical care benefits. If you find you need additional assistance with these options, call the Blue Cross Blue Shield of South Carolina Customer Service Line at 1-800-325-6596.

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Participating in Medical

Eligibility

If you are a full-service employee of the WSRC Team, then you are eligible for medical care coverage on your first day of employment. Retirees of the WSRC Team (since 4/1/89) with at least 15 years of eligibility service, and eligible survivors, are eligible for medical coverage under Health Choice (except for Blue Choice HMO). WSRC Team employees who have been approved for Total and Permanent Disability benefits are eligible for medical care benefits for up to 24 months.

However, retirees of DuPont Savannah River Plant (retirements prior to 4/1/89) — and their dependents (including those dependents of DuPont retirees who normally would be eligible for WSRC/BSRI Health Choice medical coverage due to their status as an active WSRC Team employee, a WSRC Team retiree, or a Total and Permanent Disability recipient of the WSRC Team) — who are eligible for DuPont/SRP medical coverage, are not eligible to participate in the WSRC/BSRI medical options described in this book. BSRI employees participating in union benefits are also ineligible.

Enrolling for Coverage

If you and your spouse are employees or retirees of the WSRC Team, you cannot be covered both as an employee and also as a dependent.

During the Health Choice enrollment process, you will be asked to elect:

- Prime Choice, Standard Choice, Basic Choice, Blue Choice HMO or no medical coverage and
- Coverage for yourself only, you and one dependent, or you and two or more dependents.

NOTE: If you and your spouse are both employees and/or retirees of the WSRC Team, you will be asked if you want to be covered as an employee or as a dependent. See page 3 for Special Rules for "Dual Couples."

Upon employment, you will have two weeks to complete and return the Health Choice enrollment form to Benefits Administration. If you return your form within the two-week period, your coverage will be effective on your first day of employment as a full-service employee. Otherwise, you will be placed in Basic Choice coverage for yourself only, and coverage for your eligible dependents can begin no earlier than January 1 of the following year (that is, if you elect to cover them during the next annual enrollment period), or if you have a Qualifying Family Status Change.

The premium contribution for the coverage you select will be based on your applicable pay period. Premium contributions are not pro-rated in accordance with your employment date or qualifying event date.

Coverage for your eligible dependents, if you elect to cover them, begins at the same time as your coverage or the effective date of your qualifying event, whichever applies. You must name the dependents to be covered (and provide their Social

Security numbers if they have been issued by the Social Security Administration). However, if on the day immediately prior to the effective date of coverage, one of your dependents is confined in the hospital, coverage for that dependent will be delayed until the date immediately after he or she has been discharged from the hospital.

If you are enrolled in Blue Choice HMO coverage and either you or your eligible dependent moves to an area not served by a participating HMO, you will be allowed to discontinue your enrollment in Blue Choice HMO and enroll yourself and your dependents in either Prime, Standard or Basic Choice medical coverage.

Eligible Dependents

Your eligible dependents include your lawful spouse (in accordance with state law in your state of residence) and your "children," including your own children, legally adopted children, or stepchildren who primarily reside with you, and children supported solely by you for whom you have been appointed legal guardian. Your adopted children are covered from the time they are legally placed with you. You will be required to provide proof of legal guardianship or adoption.

Be sure to add a new baby to your coverage within 60 days after the baby's birth, even if a Social Security number hasn't been assigned. Call Benefits Administration for details.

Your "children" also include children covered by a Qualified Medical Support Order which requires the Company to provide medical coverage for the children. The Qualified Medical Support Order must be properly served on the WSRC Team employee and will need to be qualified by the WSRC/BSRI Health Choice Medical Plan Administrator. Benefits Administration will need a copy of the order, and the employee will be required to complete a new Health Care Enrollment/Change form within 60 days of the qualifying event.

In order to be eligible for coverage, your "children" must: be unmarried; be under age 20; primarily reside with you in a regular parent/child relationship (or living at school while a full-time student); and you must be able to claim them as dependents on your current federal income tax return. Medical coverage may be extended up to age 25 for full-time students at accredited institutions. Blue Cross Blue Shield of South Carolina is responsible for determining student eligibility, which will be reviewed every year.

Newborns will not be automatically covered under the mother's coverage for the baby's initial hospitalization. Therefore, you should add any new baby to your coverage as soon as possible, but it must be done within 60 days.

To add a dependent to your coverage, you must submit a "Health Care Enrollment/Change Form" to Benefits Administration (730-1B) no later than 60 days from a Qualifying Family Status Change Event.

If your unmarried child is totally and permanently disabled and over the age of 20, the disability must have begun before age 20 (effective 1/1/98) and your child must remain continuously disabled beyond the age limit to be eligible for coverage. You will be requested to periodically provide proof of total and permanent disability to continue the child's eligibility under the Health Choice medical options.

Dependents of DuPont/SRP retirees are ineligible for WSRC/BSRI Health Choice medical coverage as noted under the "Eligibility" section on page 1.

Important information concerning surviving spouses and dependent children is noted on page 40 — "If you die..."

Benefits Administration reserves the right to request, at any time, documentation as proof of any dependent's eligibility, as well as the right to remove any ineligible dependent retroactively from coverage, including the right to seek reimbursement for claims paid on any ineligible dependent.

Consider your Health Choice medical option carefully. Remember, your election must stay in effect for the full calendar year — unless you have a "Qualifying Family Status Change" (marriage, new birth, spouse loses coverage, etc.) under Internal Revenue Service rules. Notify Benefits Administration of any Family Status Changes within 60 days and follow the instructions in the Overview book for requests to change elections. Qualifying Family Status Changes that are approved by Benefits Administration will be effective as of the "event" date as long as Benefits Administration is notified within 60 days.

Special Rules for "Dual Couples"

"Dual couples" are WSRC Team employees (or WSRC Team retirees) who have a spouse who also works for (or is retired from) the WSRC Team. Dual couples cannot be covered both as a dependent and as an employee/retiree under the medical options. In addition, no dependent child may be covered by more than one WSRC Team "parent" employee or retiree.

For example, you may elect to cover your spouse and your child, while your spouse elects "covered by spouse" and is your dependent. Alternatively, you may elect coverage for yourself and your child, while your spouse elects employee only coverage. (When you make this latter choice in this example, you and your spouse may elect to be covered by different medical options.) But, you and your spouse may not cover each other or both cover the same child.

Identification Cards

Once you make your medical coverage election, you will receive a Blue Cross Blue Shield of South Carolina identification (ID) card. You'll automatically receive two ID cards if you've elected to enroll dependents. The ID card provides information needed by the hospital, doctor or other health care provider to prepare and submit your claim for processing. If you should need additional cards, or a replacement card, call Blue Cross Blue Shield Customer Service at 1-800-325-6596.

When Coverage Ends

Your coverage ends when you no longer elect to be covered by one of the medical options. Your coverage also ends when you no longer meet eligibility definitions.

Coverage for your dependents ends when you no longer elect to cover them (during an annual enrollment), they no longer meet the eligibility requirements, a "Qualifying Family Status Change" occurs (as a result, you elect to eliminate a dependent from medical coverage), or your coverage ends. You will be required to provide proof of the qualifying event within 60 days of the event; otherwise, your dependents will not have coverage under your WSRC/BSRI option, they will not be eligible for COBRA continuation coverage, and you will not be able to receive a refund of any premium contribution overpayments. In the event of a divorce, the "60-day clock" begins at the date of the final divorce decree.

Do not call Blue Cross Blue Shield or Value Behavioral Health with information on a family status change — Contact Benefits Administration instead.

Coverage for you and your dependents ends on the last day of your applicable pay period. Premium contributions are not pro-rated in accordance with your termination date. In other words, you'll have to pay the full premium contribution for the pay period in which you terminate employment. In certain situations, you and your dependents may be eligible to continue coverage. See "Coverage Continuation in Special Situations" in this book and COBRA continuation coverage in the General Information book.

Your Cost for Coverage

You and the WSRC Team share in the cost of Health Choice Medical coverage. The amount of your premium contribution depends on the medical option you elect and whether you elect coverage for yourself only or you and your dependents. As an active employee, your premium contributions are deducted from your pay before Social Security and federal and state income taxes are computed and withheld. If you are a retiree, survivor or Total and Permanent Disability recipient, your premium contribution is deducted from your after-tax monthly pension benefit. The premium contribution is reviewed and adjusted annually. You will be notified of your premium contribution amount at the time of annual enrollment.

Using the Health Care Flexible Spending Account

If you are an active employee, you can use your Health Care Flexible Spending Account (FSA) in conjunction with coverage under the medical options. The Health Care FSA can be used to help pay for your deductibles, copays, and coinsurance amounts, as well as expenses that exceed the reasonable and customary (R&C) amount. You can also use the Health Care FSA to pay for expenses not covered under the Health Choice Medical options that fall within IRS guidelines. For more details and information on the Health Care FSA, see the Flexible Spending Accounts book.

How the Medical Options Work

When you enroll in Health Choice, you choose the level of coverage that's right for you — or you can elect no medical coverage.

Prime Choice

This option gives you the choice of receiving medical care from providers who have been chosen to be part of the Blue Cross Blue Shield Medical Network or going to a provider who is not part of the Medical Network.

When you go to a Network doctor, you pay a $10 copay for the office service, which might consist of one or more of the following: exam, in-office lab work or in-office x-ray. If you receive certain additional covered services (e.g., surgery performed in the doctor's office), your cost (coinsurance) is 10% of the discounted fee for the additional covered services plus your $10 copay. (See the guidelines shown in the left margin of this page.)

If you go to a non-Network provider, your cost (coinsurance) for covered services will be 30% of the reasonable and customary (R&C) allowance, after you have paid your deductible. Non-Network providers may "balance bill" you up to the amount of the total charge.

For non-Network services, you must pay a deductible before Prime Choice begins to pay. The individual annual deductible is $200 per person, $400 for your entire family. The individual out-of-pocket maximum for covered services is $1,000 per person or $2,000 for your entire family in a calendar year. Your out-of-pocket maximum includes your deductible and coinsurance, but not your office service copay or charges incurred for non-covered expenses. (Refer to pages 8 to 10 for more information on the deductible and out-of-pocket maximum.)

An office service copay does not go toward the deductible or out-of-pocket maximum.

Some services are not covered at all unless you use specific providers. For example, scheduled preventive care services are not covered unless a Network doctor is utilized.

For certain types of services, you will find there is no Network provider. In these instances, the coinsurance amount you pay is determined by the type of expense incurred.

When to Pay Your Office Service Copay ($10 or $20) or Coinsurance Amount (10% or 20%) Under Prime and Standard Choice

The following provides you with guidelines on when to pay your copay or coinsurance amounts when you go to a Network provider:

Pay your copay:

- Doctor's office visit
- Office visit with lab and/or x-ray
- Lab and/or x-ray only in Network doctor's office

Pay your coinsurance:

- Prenatal care that is billed under the surgery code for total obstetrical (OB) care
- Surgery performed in the Network doctor's office
- Allergy or hormone injections when performed by a nurse and billed with no other service from that doctor's office on that date (other injections require a copay)
- Physician hospital services
- Laboratory work that your Network doctor sends to an outside laboratory, or x-rays performed outside the doctor's office.

Both Prime Choice and Standard Choice offer a choice of Network and non-Network care. Each time you need medical treatment, you have a choice of using a Blue Cross Blue Shield Network provider or using a provider outside the

Standard Choice

This option is similar to Prime Choice in that it provides a higher level of coverage if you use a Blue Cross Blue Shield Network provider. And, as with Prime Choice, you have the choice to go to a non-Network provider. The difference is that the office service copay, deductible and out-of-pocket maximum are higher under Standard Choice.

When you go to a Network doctor, you pay a $20 copay for the office service, which might consist of one or more of the following: exam, in-office lab work or in-office x-ray. If you receive certain additional covered services (e.g., surgery performed in the doctor's office), your cost (coinsurance) is 10% of the discounted fee for the additional covered services plus your $20 copay. (See the guidelines in the left margin on page 5.)

If you go to a non-Network provider, your cost (coinsurance) for covered services will be 30% of the reasonable and customary (R&C) allowance, after you have paid your deductible. Non-Network providers may "balance bill" you up to the amount of the total charge.

For non-Network services, you must pay a deductible before Standard Choice begins to pay. The individual annual deductible is $400 per person, $800 for your entire family. Your out-of-pocket maximum for covered services is $2,000 per person or $4,000 for your entire family in a calendar year. As with Prime Choice, your out-of-pocket maximum includes your deductible and coinsurance, but not your office service copay or charges incurred for non-covered expenses. (Refer to pages 8 to 10 for more information on the deductible and out-of-pocket maximum.)

Some services are not covered at all unless you use specific providers. For example, scheduled preventive care services are not covered unless a Network doctor is utilized.

Just as with Prime Choice, you will find that for certain types of services there is no Network provider. In these instances, the coinsurance amount you pay is determined by the type of expense incurred.

Basic Choice

This option does not involve a requirement of utilizing Network providers in order to receive a higher level of benefits. Most charges under Basic Choice are subject to a much higher deductible and reimbursed at 80% of reasonable and customary charges. Some preventive services are also covered (see page 29 - "Early Detection Services.")

Under this option, you pay the lowest amount in premiums, but your deductible and coinsurance amounts are relatively high. The individual deductible (for one person) is $1,000 and is applied before you are reimbursed for covered services. The deductible for your entire family is $2,000. After you have paid your deductible, the option then reimburses you for covered expenses at 80% of reasonable and customary charges (70% of R & C when you use an emergency room for routine, non-emergency care). When combined, the maximum you will pay out of your pocket in deductibles and coinsurance amounts for covered services will be $4,500 for one person and $9,000 for your entire family in a calendar year. Like Prime Choice and Standard Choice, you pay the full cost of non-covered expenses.

Refer to the chart on page 12 for a listing of types of expenses and the option's coinsurance amount.

How the Options Are Similar

In many ways, all three options are alike. They...

- *Cover the same health care expenses overall* (preventive care is one exception — these expenses are much more limited under Basic Choice). Read about the covered expenses beginning on page 21.
- Each includes the identical Mental Health and Substance Abuse treatment services, as described on pages 30-31.
- *Exclude the same expenses.* Exclusions are listed beginning on page 32.
- Are designed so that your share of the cost is limited when the cost of covered treatment exceeds specified amounts (annual out-of-pocket maximum expenses for covered services).
- Provide the same maximum annual benefits for covered services.

Each option has provisions on deductibles, out-of-pocket expenses, reasonable and customary amounts and annual maximums. The following chart lists your deductibles, out-of-pocket amounts and annual maximums, which are further explained below.

	Prime Choice	Standard Choice	Basic Choice
Annual Deductible	$200/person $400/family	$400/person $800/family	$1,000/person $2,000/family
Annual Out-of-Pocket Maximum for Covered Services	$1,000/person $2,000/family	$2,000/person $4,000/family	$4,500/person $9,000/family
Annual Maximum Benefits	$1,000,000 per person	$1,000,000 per person	$1,000,000 per person

Deductibles

Under each option, there is an annual deductible. A deductible is an amount you pay each year before the plan begins to pay benefits for certain covered medical services. Under Basic Choice, the deductible applies to all services. Under Prime Choice and Standard Choice, the deductible applies only to services provided and billed by a non-Network provider, as well as prescription drugs, chiropractic treatment and non-emergency use of the Emergency Room (see chart on page 12).

The individual deductible is the amount that must be paid by one person each calendar year. The family deductible is twice the individual deductible. It can be met two ways:

- When two family members each meet their individual deductible amount, or
- When one family member meets his or her individual deductible amount and the expenses of all other family members combined meet or exceed the second individual deductible amount.

There is no carryover of unsatisfied deductible amounts from one year to the next. Your deductible amount starts over each January.

Do These Expenses Count Toward Your Deductible?*

Yes	No
• Covered services rendered by non-Network providers, if you are enrolled in Prime Choice or Standard Choice • All covered expenses, if you are enrolled in Basic Choice • Prescription drugs • Non-Emergency use of the Emergency Room • Chiropractic Treatment	• Copays for Network doctors' office services • The 10% coinsurance amount you pay for services provided by Network doctors • Expenses that are not covered by your medical option • Penalties incurred for hospital stays that have not been pre-certified • Expenses above what is considered the reasonable and customary (R&C) allowance for each covered service • Expenses for treatment of mental health and substance abuse, as described on page 30-31 (Note: The mental health and substance abuse benefits have separate plan benefits.)

*For additional information on services which are subject to the deductible, refer to page 12.

Out-of-Pocket Maximum

The out-of-pocket maximum is the most you will pay in deductibles and coinsurance for covered expenses during any one calendar year. Once the out-of-pocket maximum is reached, your option begins to pay 100% of eligible expenses. Essentially, the out-of-pocket maximum is designed to protect you against having to pay extraordinary medical bills in a given year.

The family out-of-pocket maximum works the same way as the family deductible. Once one family member has reached the maximum for the year, the expenses of all other family members can be combined to reach the family out-of-pocket maximum amount.

Some charges are not counted toward the out-of-pocket maximum. You are responsible for those expenses whether or not you've reached your out-of-pocket maximum. Check out the chart below for more specifics.

Do These Expenses Count Toward Your Out-of-Pocket Maximum?

Yes	No
• Your deductibles — $200/$400, $400/$800 or $1,000/$2,000 — depending on the option you are enrolled in	• The $10 or $20 copay for Network doctors' office services under Prime Choice or Standard Choice
• Your coinsurance amounts — 10%, 20% or 30% — for most medically necessary services	• Medical expenses that are not covered by your medical option
• Your coinsurance share for covered early detection preventive care expenses under Basic Choice	• Penalties incurred for hospital stays that have not been precertified
	• Expenses above what is considered the reasonable and customary (R&C) allowance for each covered service
	• All mental health and substance abuse services which are covered under a separate plan managed by Value Behavioral Health (see pages 30-31)

Reasonable & Customary (R&C)

Reimbursement for treatment and services received from non-Network providers — when you participate in Prime Choice or Standard Choice — and for all treatment and services under Basic Choice is based on the reasonable and customary, or R&C, charge.

R&C limits do not apply to Network charges since Network providers have contractually agreed with Blue Cross Blue Shield to discounted rates for their services. You pay a portion of these pre-negotiated fees with the $10 or $20 copay and/or your coinsurance share.

R&C charges are determined by utilizing a nationwide database from the Health Insurance Association of America and by taking into account:

- The normal range of fees charged by providers in your geographic area for similar services, and
- Any unusual circumstances.

If your non-Network expenses are considered more than reasonable and customary by Blue Cross Blue Shield, you will be responsible for paying the additional amount. These charges will not count toward your deductible or out-of-pocket maximum. You may want to discuss charges that are above the reasonable and customary amount with your non-Network provider to be certain that the bill is correct and complete.

Annual Maximum Benefits

Regardless of the option you choose, the maximum benefit payable by the plan is $1,000,000 per person per year.

Summary of Medical Options

The following chart indicates how the Health Choice Medical options reimburse you for covered services. For information on the amount of your deductibles and out-of-pocket expenses, refer to the chart on page 8.

Expenses	Prime Choice		Standard Choice		Basic Choice
	Network Provider	Non-Network Provider	Network Provider	Non-Network Provider	
Physician's office services (exams, lab tests, x-rays)	$10 copay/visit (plus 90% for surgery in office) No deductible	70% R&C After deductible	$20 copay/visit (plus 90% for surgery in office) No deductible	70% R&C After deductible	80% R&C After deductible
Preventive care office visits (based on schedule)	$10/copay/visit Maximum Benefit of $225*/person/year No deductible	Not Covered	$20 copay/visit Maximum Benefit of $225*/person/year No deductible	Not Covered	Limited early detection services 80% R&C After deductible
Diagnostic x-ray and lab tests, when not performed in a physician's office	90% No deductible	70% R&C After deductible	90% No deductible	70% R&C After deductible	80% R&C After deductible
Allergy or hormone injections by nurse in physician's office	90% No deductible ($10 copay if other services also provided)	70% R&C After deductible	90% No deductible ($20 copay if other services also provided)	70% R&C After deductible	80% R&C After deductible
Hospital, surgical and most other medical services	90% No deductible	70% R&C After deductible	90% No deductible	70% R&C After deductible	80% R&C After deductible
Radiology, anesthesiology, pathology (RAP)	90%** No deductible	70% R&C After deductible	90%** No deductible	70% R&C After deductible	80% R&C After deductible
Hospice care	90% No deductible	70% R&C After deductible	90% No deductible	70% R&C After deductible	80% R&C After deductible
Home health care and physical/occupational therapy	90% No deductible	70% R&C After deductible	90% No deductible	70% R&C After deductible	80% R&C After deductible
Durable medical expenses (must be pre-authorized if cost exceeds $500.00)	90% No deductible	70% R&C After deductible	90% No deductible	70% R&C After deductible	80% R&C After deductible
Podiatry	$10 copay/visit 90% for surgery in office No deductible	70% R&C After deductible	$20 copay/visit 90% for surgery in office No deductible	70% R&C After deductible	80% R&C After deductible
Chiropractic treatment	Not Applicable	80% R&C After deductible Maximum Benefit of $750/person/year	Not Applicable	80% R&C After deductible Maximum Benefit of $750/person/year	80% R&C After deductible Maximum Benefit of $750/person/year
Emergency room use for life threatening, acute or urgent care	90% No deductible	90% No deductible	90% No deductible	90% No deductible	80% R&C After deductible
Emergency room use for routine care	70% R&C After deductible	70% R&C After deductible	70% R&C After deductible	70% R&C After deductible	70% R&C After deductible
Prescription drugs (You must show your Blue Cross Blue Shield ID Card at participating pharmacies.)	80% of discounted amount After deductible	80% of retail amount After deductible	80% of discounted amount After deductible	80% of retail amount After deductible	80% After deductible

* The $225 limitation includes a well-care examination, clinical laboratory tests and x-rays performed in the doctor's office in which there is no corresponding diagnosis (routine, well-care only) and immunizations provided as part of the routine physical exam.

** If you are at a Network facility but do not have an in-Network RAP professional, you will be covered at 90% of R&C, no deductible.

Your Share of Expenses

Whether you enroll in Prime Choice, Standard Choice or Basic Choice, there are certain expenses you are responsible for:

- The deductible, coinsurance amounts and copays,
- Any non-Network expenses above the reasonable and customary level,
- Expenses not covered,
- Charges that exceed the maximum annual benefit amount,
- Charges that exceed the option's limitations on certain services,
- Any charges for procedures that are not considered to be medically necessary, and
- Charges for services of providers who are not licensed in the state in which their services are provided, when state licensure is required for performance of the services provided.

Under Prime Choice and Standard Choice, minor surgical procedures performed by a physician, or allergy or hormone injections administered by a nurse in a Network doctor's office are paid at 90%. The $10 or $20 copay does not apply unless there are additional services performed on the same date by the same

The Medical Provider

Blue Cross Blue Shield's Medical Network is an organization of doctors and other health care providers who agree to undergo an extensive screening process and provide care at contractually discounted rates. Before being admitted to the Network, a provider is evaluated against credentialing standards. The review process considers a variety of components, including education, training, licensing and patient service. Also reviewed is the provider's record for treatment patterns.

Use Your Network Provider Directory

To take advantage of the Network, use your Network Provider Directory to locate doctors and other Network providers available to you. The providers in the Network may sometimes change. When you make an appointment, it's a good idea to ask whether the provider is still participating in "Blue Cross Blue Shield's PPO (Preferred Provider Organization) Network," or call Blue Cross Blue Shield. Network Provider Directory updates (addendums) are prepared on an unscheduled basis, but the current participation status of a provider in South Carolina or the greater Augusta, GA area can be determined by calling the Customer Service Line at 1-800-325-6596. For providers outside of this area, call 1-800-810-2583.

Blue Cross Blue Shield has established medical networks in most parts of the United States. Blue Cross Blue Shield can mail a copy of a Network Provider Directory to your home address upon request.

Network Discounts... the Advantage

One of the important ways Networks can give you an advantage is by saving you money through discounts. Network providers are not allowed to charge a total amount that's more than what they've agreed to accept in their contract with Blue Cross Blue Shield. In other words, Network doctors, hospitals and other providers have already agreed to charge pre-negotiated rates. So by using a Network provider, you're paying a portion of a discounted price.

On the other hand, if you go to a non-Network doctor, the amount you pay is based on R&C (reasonable and customary) limits. R&C limits are set by Blue Cross Blue Shield and are based on data which indicates what is usually charged by doctors and other providers in the communities where the services are provided. If your expenses are considered higher than the R&C limit, you are responsible for paying your non-Network provider the additional amount.

Blue Cross Blue Shield's Medical Network is available to you nationwide and in some foreign countries. You get the maximum benefit when you use it.

Other Important Facts About the Network...Only for Prime Choice and Standard Choice Participants

When You Visit a Network Doctor's Office

When you visit a Network doctor, make sure you show your Blue Cross Blue Shield ID card. Using information on your ID card, the Network provider will file a claim for services rendered to the Blue Cross Blue Shield organization contracted by him or her for PPO Network Services. For example, a Blue Cross Blue Shield PPO doctor in Los Alamos, NM would file a claim to Blue Cross Blue Shield of New Mexico.

Generally, when seeing a Network doctor, you pay just your $10 or $20 copay at the time you receive care (there are some exceptions; for example, minor surgery performed in the office). Most Network doctors will collect the remainder of their fees directly from Blue Cross Blue Shield and then bill you if there is any balance due for any services not covered under the medical option you've chosen.

If you visit a doctor who is not in the Network, you should still present your ID card so the receptionist can check your eligibility and coverage. In many cases, you will have to pay a non-Network provider in full at the time of the visit and then file a claim for reimbursement with Blue Cross Blue Shield of South Carolina.

If another medical insurance plan (for example, your spouse's employer's plan) provides primary coverage on one or more of your dependents, certain Coordination of Benefits (COB) rules apply. Refer to the COB section in this book on page 35.

When You Must be Hospitalized or Need to See a Specialist

If your doctor is in the Network and he or she needs to refer you to another medical provider, ask your doctor if he or she can refer you to a specialist or hospital in the Network so you always receive maximum benefits.

A referral from a Network doctor is no guarantee that the specialist or hospital you are referred to is in the Network. If you are not certain whether a provider is in the Network, call the Blue Cross Blue Shield Customer Service Line (1-800-325-6596) and ask, or call the provider directly.

You are free to get a referral to any specialist or hospital that you and your doctor agree to, but it is up to you to make certain that the providers are participants in

When You Are Away From Home

If you are travelling within the U.S. and need care, your Network coverage goes with you. But, when your treatment is of a non-emergency nature, be sure to call Blue Cross Blue Shield to determine if there is a Network provider that can meet your needs in the area where you're staying. If one is not available, your care will be covered on a non-Network basis (70% of R&C after your deductible has been met). If travelling to other parts of South Carolina, call 1-800-325-6596. If travelling outside South Carolina, call 1-800-810-2583.

If you are travelling outside the U.S., call Blue Cross Blue Shield Customer Service (1-800-325-6596) to find out if there are Network providers in the country you'll be travelling to. If Network providers are not available, then you will be responsible for paying any charges you incur (emergency or non-emergency). When you return to the U.S., file a copy of your receipt with a Medical Benefits Claim Form to Blue Cross Blue Shield of South Carolina. BCBS-SC will reimburse you for the covered expense — at 70% of R&C after deductible for non-emergency services and 90% for emergencies.

If You Have Questions About Your Coverage...

Call the Blue Cross Blue Shield Customer Service Line at 1-800-325-6596. Customer Service representatives are available Monday through Friday 8:30a.m.- 4:30p.m. to:

- Answer questions about your Health Choice benefits,
- Verify which providers are in the Medical Network,
- Provide additional information about Network providers,
- Help you with Network-related problems, and
- Discuss the status of medical

In an emergency, get the care you need immediately. Then, if you are admitted as a hospital inpatient, call BCBS-SC's Pre-Admission Review Line (1-800-327-3238 in South Carolina or 1-800-334-7287 outside of South Carolina) within one business day after your emergency admission. Your treatment will be covered at 90% (80% of R&C after the deductible under Basic Choice) if the care provided was related to a life threatening, acute or urgent situation, at either Network or non-Network hospitals.

NOTE: Routine medical care provided by an emergency room will be reimbursed at 70% of R&C after deductible — regardless of the hospital or doctor you use.

Important words to keep in mind when you think of "emergency" are life threatening, acute and urgent care. Check the Glossary beginning on page 43 for a full description.

If Your Child is Away at School

Most times, children away at school can use the school's infirmary or schedule procedures when they come home. You can also find out whether a Network provider is available in the vicinity of the school by calling 1-800-325-6596 for providers in South Carolina and the greater Augusta, GA area or 1-800-810-2583 for providers outside this area.

Pre-Approvals

Regardless of the medical option you choose, Health Choice Medical offers several programs designed to help you become a better consumer of health care services and to help keep costs of medical services down for both you and WSRC.

As described in this section, you should call Blue Cross Blue Shield to:

- Have every hospital admission approved,
- Receive prior authorization for certain medical services,
- Receive assistance in locating a Network specialist when you want a second surgical opinion, and
- Access the services of a case manager when a catastrophic or long-term illness occurs.

You must follow certain procedures to avoid financial penalties.

Prior Authorization and Pre-Admission Certification — Required for Certain Services

Blue Cross Blue Shield requires that all inpatient hospital stays and certain other medical services meet the medical necessity provisions of the options. While Network providers are familiar with pre-admission certification procedures and requirements — which means there is less likelihood of a conflict in cooperation by a Network doctor or facility — prior authorization or pre-admission certification is required under all three options, Prime Choice, Standard Choice and Basic Choice, for any of the following services:

- Any inpatient admission
- Any home health services (nursing visits, infusion therapy, physical therapy, occupational therapy or speech therapy provided in the home)
- Any admission to an extended care facility (inpatient rehabilitation, skilled nursing facility)
- Any rental or purchase of durable medical equipment that exceeds $500.00
- Any transplant
- All hospice care
- Any private duty nursing

If you are being admitted to a Network facility, it is the responsibility of the facility to obtain precertification for all elective admissions at least 48 hours prior to the admission; and in the case of emergency admissions, within one business day of the admission.

If you are admitted to a facility that is not part of the Blue Cross Blue Shield Network, it is your responsibility to notify Blue Cross Blue Shield. If you are scheduled for an elective admission at a non-Network facility, you or your admitting physician must notify Blue Cross Blue Shield at least 48 hours prior to the elective admission to obtain precertification, or within one business day after admission in case of an emergency.

For hospital admissions and prior authorization of certain other services as outlined above, call Blue Cross Blue Shield. If calling from within South Carolina, call 1-800-327-3238 or from outside South Carolina, call 1-800-334-7287. These numbers are shown on your Blue Cross Blue Shield ID Card.

When you call, a Blue Cross Blue Shield nurse will request the following information:

- Employee's name, Social Security number, address and phone number,
- Patient's name,
- Name, address and phone number of the attending physician, and
- If a hospital admission, the name and address of the hospital, scheduled admission date, and reason for admission, or
- If prior authorization for another medical service is requested, the details regarding its medical necessity.

A Blue Cross Blue Shield registered nurse or physician consultant will in turn contact your physician to confirm the need for hospitalization or other medical services. Once that contact has been made, you will receive a telephone call or letter from Blue Cross Blue Shield notifying you whether your hospital stay or other medical service has been certified or authorized.

What if You Don't Precertify Your Hospital Stay?

If you fail to make the precertification phone call for a non-Network hospital admission...

you will incur a $200 penalty which does not count toward your deductible or out-of-pocket maximum.

If you follow precertification procedures but your requested hospitalization is not certified and you go into the hospital anyway...

no hospital benefits will be paid for the duration of your stay.

If you stay in the hospital beyond the days certified by Blue Cross Blue Shield...

no hospital benefits will be paid for the extra days.

These unpaid expenses will be your responsibility and will not count toward your deductible or your annual out-of-pocket maximum.

Second Surgical Opinions

If your doctor recommends elective, non-emergency surgery, you might want to get a second doctor's opinion to be sure you really need the operation. It's not required, however. Surveys indicate that some operations are not medically necessary. Other types of treatment, like medication for example, might be just as effective to treat a given problem.

The Health Choice medical options cover services related to a second surgical opinion, or a third surgical opinion in the event your second surgical opinion conflicts with your doctor's original diagnosis or recommendation. You will be responsible for any applicable copay and/or employee coinsurance.

Any surgeon providing a second or third opinion should not be associated in any way with the surgeon who gave you the initial recommendation, in order to prevent any possibility of a conflict of interest.

Individual Case Management

Blue Cross Blue Shield administers an Individual Case Management program which is available if a catastrophic or long-term illness occurs. A registered nurse case manager assists the patient and family in coordinating the necessary care from various sources. Participation is voluntary. Call 1-800-327-3238 from within South Carolina or 1-800-334-7287 from outside South Carolina if you need this service.

Depending on the individual situation, the case manager may authorize coverage for a proposed treatment that ordinarily would not be covered. The treatment must be approved by you and your physician, and must be determined by the case manager to be less costly to the plan than its alternative covered treatment.

Transplants–Blue Quality Centers of Excellence

Blue Cross Blue Shield — using its resources as the nation's largest health care federation — has contracted with many of the leading transplant care facilities in the nation to provide these services. These institutes have specific expertise in transplant procedures and post-transplant care.

If you or your covered dependent is considering any type of transplant, you or your physician should call the Blue Cross Blue Shield of South Carolina toll-free pre-admission review number shown on the front of your ID card to discuss the care required. If the transplant is determined to be medically necessary by Blue Cross Blue Shield of South Carolina, you will be directed to the Blue Quality Center best qualified to perform the specific transplant required.

If you decide to use the specified Blue Quality Center, all hospital and physician charges for evaluation, transplant and post-operative care will be paid the same as any other covered Network service. You will also be reimbursed for limited travel and housing accommodation expenses for the transplant patient and one family member or companion.* There is a $10,000 limit on reimbursement for travel and housing. WSRC/BRSI Health Choice benefits for the Prime, Standard and Basic Choice medical options include the following general travel reimbursement guidelines under the Blue Quality Centers of Excellence program:

- The cost of round-trip airline tickets (or personal vehicle travel expenses reimbursed at the existing SRS mileage rate) for the pre-transplant work-up, the actual transplant procedure and post-transplant care, for both the patient and a family member* or companion (airline ticket receipts are required, if flying),

- The actual cost of lodging (with a receipt, excluding any incidentals such as phone calls, etc.) up to $100 per day (combined expenses from the patient and a family member* or companion), and

- The actual cost of meals (with a receipt, excluding any incidentals such as tips, etc.) up to $40 per day per person for your family member* or companion, and up to $40 per day for the patient when the patient is not hospitalized during the trip.

Blue Cross Blue Shield can provide you with specific reimbursement guidelines and instructions.

* Travel expenses for two family members are reimbursable when the patient is a dependent child.

Covered Medical Expenses

The Prime, Standard and Basic Choice medical options cover a portion of most *medically necessary* services and supplies, both inside and outside of a hospital. Care is *medically necessary* if Blue Cross Blue Shield determines it is appropriate for the diagnosis, care or treatment of an illness, injury or pregnancy.

How much is paid depends on the option you choose and — with Prime Choice and Standard Choice — your Network or non-Network usage.

The chart on page 12 shows the percentages the options pay for a variety of covered expenses.

Eligible Network charges are based on negotiated arrangments between the provider and Blue Cross Blue Shield. Eligible non-Network charges — and all Basic Choice charges — are based on R&C charges, as described on page 11.

Hospital Services and Supplies

The Prime, Standard and Basic Choice medical options cover a semiprivate room and board in a recognized hospital or approved rehabilitative facility.

If you stay in a private room because no semiprivate room is available, or because your doctor determines and documents (and Blue Cross Blue Shield agrees) that isolation is necessary, the private room and board rate will be covered.

Other covered hospital expenses include charges billed by a hospital for:

- Nursing care provided by hospital staff,
- Use of operating, delivery, recovery and treatment rooms,
- Use of intensive care and coronary units,
- Inhalation therapy,
- Laboratory and other medical diagnostic tests, such as electrocardiograms,
- Medicines, supplies and dressings,
- Anesthesia supplies,
- Appliances used in the hospital,
- Diagnostic x-rays, Magnetic Resonance Imaging (MRI) and Computerized Axial Tomography (CAT) scans,
- Routine nursery care,
- Blood typing and matching, administration of blood and blood plasma,
- Use of a cystoscopic and other specialized procedure rooms,
- Special diets, and
- Other doctor-prescribed services and tests approved by Blue Cross Blue Shield.

Special note: Many facilities offer suitable care outside a hospital setting. See pages 23 to 25 for details.

Outpatient Services and Supplies

The Prime, Standard and Basic Choice medical options also cover most medical services and supplies that you receive as an outpatient in a hospital, including:

- Hospital facility charges for outpatient surgery (provided the charges are incurred on the day the surgery is performed),
- Fees of surgeons, assisting surgeons (when medically necessary), surgical assistants and anesthesiologists, for outpatient surgery,
- Doctors' fees for outpatient treatment,
- Diagnostic x-ray and laboratory services,
- X-ray therapy, radiation therapy, chemotherapy and electroshock therapy, and
- Emergency room services. *(Remember, though, that your payment percentage depends on whether care is of an acute, urgent or life threatening nature, or is routine. Refer to the chart outlining payment on page 12 and the box below.)*

When Should You Go to an Emergency Room?

For routine physical ailments?

No!

For medical crises?

Yes!

Emergency rooms (ERs) are specially designed to give immediate aid in cases of medical crises resulting from accidents or a sudden illness. ERs are staffed with highly-trained doctors and nurses, and outfitted with high-tech equipment. Because of this, emergency room services can be very expensive and should be reserved for life threatening, acute and urgent care. When a sudden and severe medical problem occurs, by all means go to an emergency room immediately.

Conversely, for routine physical ailments and non-threatening injuries, call your doctor and make an appointment, if necessary. If you go to an emergency room, you may have to wait several hours for a doctor because the most severe emergencies are treated first. Plus, you'll pay a lot more (70% of R&C after the deductible) for routine non-emergency treatment and you may not receive adequate

If you believe that a trip to the Emergency Room was a life-threatening, acute or urgent situation, but your Explanation of Benefits from Blue Cross Blue Shield shows that the claim was processed as a "routine, non-emergency" visit, then call Blue Cross Blue Shield Customer Service (1-800-325-6596) to discuss your particular situation.

Doctors' Services

The medical options pay a portion of the medically necessary charges for services performed by a doctor or other licensed practitioner (such as a Certified Nurse Practitioner) qualified as being covered under this plan and acting within the scope of his or her license. When office services are provided by a Network doctor, you generally pay a $10 copay under Prime Choice or a $20 copay under Standard Choice before Blue Cross Blue Shield pays the balance of the negotiated fee. Reimbursement for charges is limited to 70% of R&C after the deductible when services are provided by a non-Network physician under Prime Choice and Standard Choice, and 80% of R&C after the deductible when you participate in Basic Choice. Covered expenses include:

- Doctors' office visits,
- In-hospital consultations,
- Surgery (including medically necessary assisting surgeons' and anesthesiologists' charges), and
- Physical therapy, speech therapy and occupational therapy to restore a skill or ability lost through illness or injury.

Hospital Alternatives

The Prime, Standard and Basic Choice medical options provide coverage for care at home or in certain health care facilities that are not hospitals. In addition to the following hospital alternatives, expenses are covered if you go to a Christian Science facility or a birthing center.

Home Health Care

Through the use of a home health care agency, you may be able to shorten your hospital stay and spend your recovery time in the comfort of your own home. Prior authorization is required, as described on page 17.

Covered home health care expenses include the following services which are prescribed by your doctor:

- Part-time or intermittent nursing care by either a Registered Nurse (RN) or Licensed Practical Nurse (LPN),
- Dressings, medical supplies and prescribed drugs, and
- Laboratory services, to the extent they would have been covered if you had been hospitalized.

Refer to your Network Provider Directory for home health care organizations that are participating as Network providers, or call Blue Cross Blue Shield Customer Service.

Expenses for the following services are not covered:

- Services of a person who resides in your home or is a member of your family,
- Custodial care,
- Transportation services, and
- Any services provided when the individual is not under the continuing care of a doctor.

Extended Care Facility

If you (or a member of your family) are recovering from an illness or injury, benefits for rehabilitative care are payable for certain services and supplies. Prior authorization is required, as described on page 17.

Care at an extended care facility will be considered for coverage by Blue Cross Blue Shield if the stay is recommended by the patient's attending physician and:

- Confinement begins within 14 days after a hospital stay of at least three consecutive days,
- The patient remains under the doctor's continuing care, and
- The initial hospital stay begins while the patient is enrolled in the applicable medical option.

Covered expenses include:

- Room and board, including charges for general nursing care,
- Use of special treatment rooms, x-rays, laboratory examinations, most therapy and other medical services customarily provided to patients, and
- Drugs, solutions, dressings and casts.

If you do not have a definite need to be in a hospital, receiving medical care in another setting — such as an extended care facility, a hospice, or through a home health care agency — is often less costly, more comfortable, and just as effective.

The following expenses are not covered:

- Custodial care,
- Treatment of alcoholism, drug abuse or mental illness, or
- Care for the convenience of someone, such as a family member.

Hospice Care

Hospice care refers to the medical, psychological and nursing care provided to terminally ill patients with a life expectancy of less than six months. It permits someone with no hope of recovery to leave a hospital for a more comfortable and dignified setting. Prior authorization is required, as described on page 17. The following will be considered by Blue Cross Blue Shield as covered expenses when ordered by the patient's attending physician, and provided and billed by a hospice:

- Semiprivate room and board and special services,
- Nursing and therapy services,
- Outpatient services,
- Psychological and dietary counseling,
- Home care by professional hospice workers (other than household or family members), and
- Pain-relief treatment, including drugs and supplies.

Refer to your Network Provider Directory, or call the Blue Cross Blue Shield Customer Service Line at 1-800-325-6596 for information on hospice programs participating in the Network.

Private Duty Nursing

When a patient's condition requires constant monitoring in a hospital, the hospital is responsible for providing this care. Normally, private duty nursing is required for the management of a patient with extensive monitoring needs in the home. When private duty nursing services are recommended, the following guidelines must be followed:

- Services must be pre-authorized and determined to be medically necessary by Blue Cross Blue Shield, as described on page 17. To be sure the expenses will be covered, call Blue Cross Blue Shield to have your situation reviewed by a case manager before incurring any charges. A doctor's recommendation does not guarantee coverage.
- The provider of skilled services must be an RN or LPN.
- Custodial care services are not covered.
- Services provided by an RN or LPN who is a member of your family or who resides in your home are not covered.

Prescription Drug Discount Program

A special prescription drug discount program is provided with the Prime, Standard and Basic Choice medical options. Each option has a benefit of 80% after your annual deductible has been met. If you use pharmacies which participate in the PAID prescription network, your 80% benefit will be based on a discounted price (or the regular retail price, if it is lower). There is no discount at non-participating pharmacies (so your 80% benefit will be based on the regular retail price at non-participating pharmacies). There are some very important things to remember in order to receive maximum benefits from the prescription drug discount program:

- The PAID prescription drug discount program requires that you show your Blue Cross Blue Shield of South Carolina ID Card at participating pharmacies with every purchase. If you should forget to show your Card, you risk incurring out-of-pocket expenses that are not reimbursable under the medical options. That's because the discounted amount of the drug is considered the covered charge, and the plan pays 80% of the covered charge after you've met your annual deductible. If you haven't yet met your annual deductible, the covered charge will be applied to your deductible. If your WSRC/BSRI medical option is secondary to another medical insurance plan (for example, your spouse's employer's medical plan), you still need to show your Blue Cross Blue Shield ID Card to ensure that you will receive maximum benefits.

  Here is an example to demonstrate why it is to your advantage to show your ID Card to the pharmacy. This example assumes you have met your calendar year deductible.

Regular Retail Price of Prescription	$50.00
PAID Program Discount Price	$45.00

	If you show your ID card	If you don't show your ID card
You Pay the Pharmacy	$45.00	$50.00
Plan Pays 80% of Discounted Price	$36.00	$36.00
Your Total Expense	$ 9.00	$14.00

- When you present your Blue Cross Blue Shield ID Card, your pharmacist will recognize a code on the card and enter information into a computer. The pharmacist will then receive the discounted price electronically from the PAID system, and will charge you the lower of the PAID program discounted price or the regular retail price. After you've paid the pharmacist, you'll need to complete a Blue Rx Drug Claim Form. On the form is a space for an "authorization code." Do not write in that space since the authorization is routinely printed on your receipt from the pharmacy. Tape your receipt(s) from the pharmacy onto the form and mail it to the

address of the drug claim processing center (provided on the form). After your claim has been processed by the drug claim processing center, it will be electronically forwarded to the Blue Cross Blue Shield of South Carolina claim processing center, and you will be mailed an Explanation of Benefits for your drug claim.

- The prescription drug discount program covers up to a 90-day supply of medication. Also, 75% of the days supplied on the prescription must have elapsed before you will be allowed to have a re-fill. If you have special needs that require a longer supply, or a re-fill before the 75% rule is satisfied, or if you have other questions concerning the prescription drug discount program, contact Blue Cross Blue Shield Customer Service at 1-800-325-6596 to discuss your individual situation.

Following these rules will help you and the WSRC Team save money on prescription drugs.

If you are enrolled in Prime Choice or Standard Choice, you must use Network providers for coverage of preventive care services. Benefits for these services are not covered if you use non-Network providers.

Preventive Medical Care Benefits

One of the best ways to prevent illness is by taking care of yourself. Recognizing the importance of regular check-ups and immunizations, Prime Choice and Standard Choice include extensive preventive coverage for well baby, child, adolescent and adult care provided in a physician's office setting. (Basic Choice provides limited adult preventive care benefits through the Early Detection Program as described on page 29.)

The charts on pages 28 and 29 list the covered pediatric and adult preventive care services, and show, in general, how often and at what ages you and your family members should schedule each type of preventive care service. Always consult with your physician for specific scheduling recommendations.

Under Prime Choice and Standard Choice, preventive services provided during an office visit by a Medical Network doctor — such as well-baby care, immunizations, routine physicals and annual gynecological exams — are covered by paying your $10 or $20 office service copay (depending on the option you choose), with a limited benefit of $225.00 per person per calendar year for services provided by the Network doctor (including lab work and x-rays performed in the doctor's office).

In addition, associated diagnostic tests — outside lab work and x-ray services for mammograms, pap smears and sigmoidoscopy — that frequently can't be performed in the doctor's office are paid at 90% with no deductible, provided you use a Medical Network free-standing laboratory, radiology facility, or hospital outpatient department.

Prime and Standard Choice

Routine Physical Exam, Limited Clinical Screening Tests and Immunizations Performed in the Doctor's Office (Limited to $225* Per Person Per Year)	Every 2 months, Ages 1-18 months Once, Age 19-24 months Annually, Ages 3-4 years Every three years, Ages 5-16 years Once, Age 17-18 years
PPD (Tuberculin Skin Test)	Once, Age 9 months, and Once, Age 4-6 years
Pelvic Exam and Pap Smear (Only for females identified as high risk)	Annually, Ages 13-18 years

DPT = Diphtheria/Pertussis/Tetanus
OPV = Oral Polio
HBV = Hepatitis B
VAR = Varicella (Chicken Pox)
MMR = Measles/Mumps/Rubella
HIB = Haemophilus Influenza B
Td = Tetanus/Diphtheria Booster

Birth or 2 weeks: HBV#1	2 months: HBV#2 DPT#1 OPV#1 HIB#1	4 months: DPT#2 OPV#2 HIB#2
6 months: HBV#3 DPT#3 HIB#3	12-15 months: MMR#1 VAR HIB#4	18 months: DPT#4 OPV#3
4-6 years: DPT#5 MMR#2 OPV#4	12 years: HBV (series of 3) ONLY if not already immunized VAR ONLY if not already immunized, and with no reliable history of chicken pox	14-16 years: Td

Note: The Immunization Schedule above reflects recommendations of the American Academy of Pediatrics (AAP) and the American Academy of Family Physicians (AAFP), current as of July 1997. Always seek guidance from your child's health care provider for any individualized changes or updates to the AAP and AAFP recommendations.

**The $225 limitation includes a well-care examination, clinical laboratory tests and x-rays performed in the doctor's office in which there is no corresponding diagnosis (routine, well-care only) and immunizations provided as part of the routine physical examination.*

Prime and Standard Choice

Type of Service	Recommended Frequency
Routine Physical Exam, Limited Clinical Screening Tests and Immunizations Performed in the Doctor's Office (Limited to $225* Per Person Per Year)	Once every 2 years, Ages 19-39 Annually, beginning at Age 40
Pelvic Exam and Pap Smear	Annually, beginning at Age 19
Professional Breast Exam and Mammogram	Professional breast check with every physical exam. Screening mammogram, annually, beginning at age 40
Routine Prostate Screening Test (PSA)	Annually, beginning at Age 40
Rectal Exam/Sigmoidoscopy	Once at age 50, then once every two years thereafter
Tetanus-Diphtheria Immunization (Td) Booster	Once every 10 years
Influenza Immunization	When appropriate (high risk) per BCBS-SC guidelines, Ages 19-64 Annually, beginning at age 65
Pneumovax Immunization	Once, Age 65 or older
Hepatitis B Immunization	Once, Age 19 or older if high risk (non-occupational)

**The $225 limitation includes a well-care examination, clinical laboratory tests and x-rays performed in the doctor's office in which there is no corresponding diagnosis (routine, well-care only) and immunizations provided as part of the routine physical examination.*

Early Detection Services (Basic Choice Medical Option Only)

When you participate in Basic Choice, coverage is available to you and other adult family members for pap smears, mammograms and sigmoidoscopies, without an accompanying diagnosis. These tests have proven to be valuable tools in combatting cervical, breast and colon cancers through early detection. The following schedule of

Early Detection Service Schedule

- Pap Smears: 1 every year beginning at age 18 (earlier if high risk)
- Mammograms: 1 every year beginning at age 40
- Sigmoidoscopies: 1 at age 50
then 1 every 3 years beginning at age 51

Under Basic Choice, charges for each of these early detection tests are covered at 80% of R&C after the dedectible - whether the test is billed in conjunction with a routine examination or with a diagnosis.

Mental Health and Substance Abuse Services

Regardless of whether you elect Prime Choice, Standard Choice, Basic Choice or Blue Choice HMO, your coverage for mental health and substance abuse services will be managed by Value Behavioral Health (VBH). VBH is the largest mental health plan administrator in the United States, with a Network of providers throughout the nation.

Often, when someone needs mental health, alcohol or drug treatment, it is difficult and confusing to find the right approach and level of care. VBH will help you and your dependents find and receive appropriate care. It complements the assistance available through the SRS Employee Assistance Program (EAP) and Site Medical Department. VBH provides an independent, confidential assessment and referral service staffed and managed by trained clinicians for you and your dependents. The VBH Network is composed of licensed practitioners and facilities who meet strict credentialing requirements.

To contact VBH, call their toll-free number, 1-800-333-6557, 24 hours a day, 7 days a week. A Clinical Care Manager will discuss your problem and assess your needs. Your Clinical Care Manager also will refer you to a qualified provider in your community.

The VBH network of local providers includes inpatient hospitals, day treatment programs, specialty child and adolescent services, outpatient treatment programs, intensive outpatient alcohol and drug treatment programs, and professionals in private practice. VBH reviews the treatment you receive from providers of these services in an effort to monitor the quality of care being provided by the Network and to determine the appropriateness and medical necessity for the continuation of your treatment.

YOU MUST CALL VBH prior to seeking treatment. You also have the option to use the SRS EAP/Medical Department, which can assist you and put you in touch with VBH if necessary.

Going directly to a provider known to be in the Network is not sufficient to receive Network benefits — you must be referred by VBH!

It is important to remember that without pre–certification from VBH (either directly or through the EAP/SRS Medical Department), your treatment will not be covered. (The *only* exception is coverage for non-Network outpatient mental health treatment.) The EAP/SRS Medical Department is able to refer you to treatment programs; however, VBH must be notified of the referral prior to beginning treatment. Ultimately, it is your responsibility to make sure that VBH is pre-notified about any mental health or alcohol or drug treatment to receive Network benefits. Also, VBH must approve extensions of treatment beyond the initial pre-certification.

For emergency services, VBH clinicians are available 24 hours a day, 7 days a week. Employees must call VBH at 1-800-333-6557 for a referral for inpatient treatment. If there is risk of your (or your dependent) being a danger to yourself/himself/herself or to another person, VBH will assist the caller in getting help. This may require VBH to authorize admission to non-Network facilities. After the patient is stabilized, continued coverage may be contingent on transferring the patient to a VBH Network facility. *Again, all mental health and alcohol and drug admissions and treatment programs must be pre-certified by VBH.*

See page 38 and 39 for important information on filing claims to VBH (that is, when you use non-VBH-Network outpatient mental health providers).

Mental Health and Substance Abuse Benefits

Expenses	VBH Provider (with ongoing VBH management)	Non-Network Provider
Inpatient mental health	100% after $250 annual deductible per person* No limit on days After discharge, outpatient visit copays apply	Not covered
Outpatient mental health	$20 copay/visit No limit on visits	50% up to a maximum benefit of $25/visit Maximum 20 visits/person/year
Chemical dependency: inpatient or outpatient	100% after $250 annual deductible per person* No limit on days	Not covered

** If a patient requires both inpatient mental health services and inpatient or outpatient chemical dependency treatment services in the same calendar year, only one $250 deductible will apply.*

Charges Not Covered by the Options

The following is a list of expenses that the Health Choice medical options do not cover. This list is intended to provide you with only the more common non-covered services. It is not a complete listing. Call the Blue Cross Blue Shield Customer Service Line (1-800-325-6596) to find out if a particular service or treatment program not mentioned in this book is covered under Health Choice.

- Treatment that is not medically appropriate or necessary (see page 48),
- Routine physical examinations, diagnostic tests and immunizations under Basic Choice, except for certain early detection services as shown on page 29,
- Routine prenatal care sonograms, unless medically necessary,
- Comfort or convenience items, or personal services,
- Treatment that is not recommended and approved by a physician,
- Custodial care,
- Travel (except medically necessary transportation by ambulance), motels, apartment rentals or related expenses except those covered under the Blue Quality Centers of Excellence program (transplants),
- Services you would not be required to pay if you had no medical coverage,
- Treatment of injuries due to service in the armed forces of any government,
- Treatment of injuries due to work done for any government — federal, state or local,
- Missed appointments,
- Completion of claim forms or filing of claims,
- Treatment of injuries or diseases covered or compensated for by any Workers' Compensation or similar laws,
- Chiropractic treatment except for manipulation or treatment of musculoskeletal disorders and diagnostic x-rays in connection with such treatment by a licensed provider,
- Inpatient hospitalization for dental care, unless confinement is due to accidental bodily injury, or when a physician, other than a dentist, certifies that inpatient hospitalization is necessary to safeguard the life or health of a patient,
- Routine eye exams, eyeglasses or contact lenses, or examinations for the prescription or fitting of them (covered under Vision Care Choice),
- Hearing aids or examinations for the prescription or fitting of them,

- Care rendered to a dependent child after his or her marriage,
- For expenses incurred after December 31, 1996, services not reported within fifteen (15) months from the date of service or within one (1) year from the end of the plan year, whichever is later.
- Cosmetic surgery unless it is necessary for prompt repair of a non-occupational injury or is related to a congenital defect of an eligible newborn child (up to one year in age),
- Treatment resulting from any injury sustained or disease contracted in the performance of an occupation or work outside the WSRC Team for compensation or profit,
- Services or supplies which:
  - — are not recommended and approved by a physician,
  - — are not necessary for the diagnosis and treatment of an illness or injury (except certain covered preventive care services),
  - — exceed R&C (reasonable and customary) charge limitations,
- Services considered experimental or investigational (see page 44),
- Services incurred for any medical observation or diagnostic study when no disease or injury is revealed unless:
  - — the covered person had definite symptoms of illness or injury other than hypochondria,
  - — the observation or studies were not part of a routine physical examination,
  - — the request for benefit payment is in order in all other respects,
- Items billed separately for services solely benefiting the attending physician rather than for the diagnosis and treatment of the patient, such as pre-surgical routine testing for HIV,
- Treatment in connection with the following counseling services: marriage, family, child, career, social adjustment, pastoral or financial, except those services provided on a limited basis through the SRS Employee Assistance Program,
- Non-medically-necessary orthopedic shoes, orthotic appliances or other supportive devices for the feet, solely used for comfort or athletics,
- Radial keratotomy or other methods of refractive eye surgery,
- Medication or treatment for cosmetic purposes,
- Devices, programs or medication to aid in smoking cessation,
- Prescription drug re-fills beyond one year from the original prescription date,

- Food supplements and non-prescription drugs and medicines which do not bear the legend, “Caution: Federal law prohibits dispensing without a prescription,” except for certain medically necesary medications (for example, pre-natal vitamins) approved by Blue Cross Blue Shield,
- Charges made by a clinical pathologist, as related to automated laboratory testing, for supervising a hospital's laboratory,
- Charges for birth control devices and drugs, except as approved by Blue Cross Blue Shield as being medically necessary to treat certain diseases or conditions,
- All services related to the treatment of sexual dysfunctions, including a penile prosthesis except following prostate surgery,
- Treatment for or in connection with developmental speech therapy. (Note: Restorative speech therapy is covered when it is expected to restore speech to an individual who has lost an existing speech function resulting from disease or injury),
- Services, treatment, educational testing or training related to learning disabilities or developmental delays,
- Educational programs or services, such as dietary instructions and weight loss programs, (Note: a diabetic education program may be approved as being medically necessary, by Blue Cross Blue Shield),
- Treatment in connection with primal therapy, rolfing psychodrama, mega vitamin therapy, bioenergetics therapy, carbon dioxide therapy,
- Vision perception training,
- Any service or supply related to the diagnosis or treatment of infertility, including in-vitro fertilization and prescription drugs used for the treatment of infertility,
- Services or supplies related to the reversal of a tubal ligation or vasectomy,
- Services or supplies including medications related to the treatment of obesity, weight reduction or dietary control, except for medically necessary gastric bypass surgery or gastric stapling procedures as approved by Blue Cross Blue Shield,
- Charges related to complications of non-covered procedures,
- Services provided by non-licensed lay persons who assist in the delivery of a baby, such as a birthing coach or “doula,”
- Services of providers (persons or facilities) who are not licensed in the state in which their services are provided, when state licensure is required for performance of the services provided,
- Durable medical equipment expenses over $500 for which no pre-approval was obtained from Blue Cross Blue Shield,
- Elective abortions, unless the life of the mother is threatened if she should carry the baby to term.

Coordination of Benefits (COB)

If you have medical coverage under another group plan in addition to this one — through your spouse, for example — the total benefits you are eligible to receive could be greater than your actual expenses. To help eliminate duplicate payments, your coverage under Prime Choice, Standard Choice or Basic Choice is coordinated with payments from other group medical plans through which you have coverage. When your WSRC/BSRI medical option is the secondary plan, it will pay up to the amount of total covered charges as determined by the Claims Administrator (Blue Cross Blue Shield or Value Behavioral Health). However, the secondary payment will not exceed the difference between the total covered charges and the primary plan's payment.

If you and your spouse (through another employer) both cover your children, the plan of the parent whose birthday is first in the year

Which Plan Pays First

The plan that pays first is the one that covers you as an employee. If your child is covered by more than one plan, the plan which covers the parent whose birthday falls first in the year (month and day) pays for the dependent child before the plan covering the other parent.

However, if you are separated or divorced, the plan of the parent who has custody of the child (provided that the parent hasn't remarried) will pay before the plan of the parent who doesn't have custody. If you're divorced, but have remarried and have custody of your child, your plan will pay before the child's stepparent's plan, and the stepparent's plan will pay before the plan of the child's non-custodial parent.

If a court gives financial responsibility for the child's health care expenses to one parent, then that parent's medical plan will pay before any other plan. When none of these situations apply, the plan under which you're covered the longest will pay first.

Other plans include any medical coverage available from:

- Group, fraternal, blanket or franchise insurance,
- Prepayment coverage,
- Coverage under labor-management trustee plans, union welfare plans, employer organization plans or employee benefits organization plans, and/or
- Government programs, except Medicare.

Keep in mind that if both you and your spouse are employed by (or retirees of) the WSRC Team, under the "Special Rules for Dual Couples" (explained on page 3), you cannot be covered under the medical options as both an employee and as a dependent of another employee. As a result, you cannot have duplicate coverage under the WSRC/BSRI Health Choice Medical Options.

Each employee is covered only as an employee or as a dependent. A child is regarded as a dependent of only one employee, not both. No coordination of benefits is applicable since only one medical plan is involved.

Coordination with Medicare

As an active employee over age 65, you continue to be eligible for coverage under the WSRC/BSRI Health Choice Medical options the same as any other active employee. You also become eligible for Medicare when you reach age 65. By law, you have a choice to make. You may:

- Continue to be covered under Prime Choice, Standard Choice or Basic Choice for the same benefits available to active employees under age 65. If you make this choice, the WSRC/BSRI option you've chosen will pay all eligible expenses first. Medicare will then pay for any Medicare-eligible expenses not covered by the WSRC/BSRI option, or
- Elect Medicare as your primary coverage. In this case, you will not be eligible for any benefits under the WSRC/BSRI Health Choice medical options.

If you continue in active employment after age 65, and your spouse becomes eligible for Medicare, he or she may also choose to continue primary coverage through the WSRI/BSRI options or to be covered only under Medicare.

When you continue to work after age 65, your Medicare benefits do not begin automatically. Approximately three months before you reach age 65, you should contact the nearest Social Security office to discuss your options regarding applying for Medicare.

In considering your medical options, remember that Medicare is offered in two parts — Part A (Hospital) and Part B (Medical). Part A is available at no cost to you. When you elect Part B, you pay a premium each month. If you continue your coverage under the WSRC/BSRI Health Choice medical options while you are working, you may wish to delay enrolling in Part B.

As long as you apply for Part B promptly when you stop working, you can have Part B coverage effective on the first day of the month after you leave the WSRC Team. There is no penalty for delaying your enrollment in Part B while you continue to work.

When you are retired from the WSRC Team and age 65 or older, Medicare becomes your primary medical coverage. Since Medicare is your primary medical coverage, your benefit from the WSRC/BSRI plan, assuming you elect coverage, is based on the appropriate Medicare payment. This method of calculating payment is called a "carve out". Blue Cross Blue Shield calculates the normal benefit payable for a covered expense — for example, 90% in-Network — then "carves out" (or subtracts) what Medicare would pay for the expense. The difference between the normal benefit and the "carve out" is what Blue Cross Blue Shield would actually pay. You would then be responsible for the remaining amount up to the Medicare allowable amount.

For example, if you have a $1,000 expense from a Network provider, then Blue Cross Blue Shield would normally pay $900, or 90% of $1,000. If the Medicare allowable amount is $800 and Medicare actually pays $640 (that is, 80% of $800), Blue Cross Blue Shield would "carve out" that payment: $900 - $640 = $260. Blue Cross Blue Shield would then actually pay $260 toward the expense.

Keep in mind that the Medicare "carve out" is applied whether or not you have elected Medicare part B coverage. This provision could always be changed in the future.

Right of Recovery

When the Health Choice Medical options pay for your (or your dependent's) medical care and you have the right to recover expenses incurred for your care from another person or organization causing your injury, Blue Cross Blue Shield (or its subcontracted agent) has the right to recover the amount paid which duplicates amounts you (or your dependent) receive through a lawsuit or a settlement with another party or insurer. You have a legal obligation to help Blue Cross Blue Shield (or its subcontracted agent) and WSRC recover the amount paid.

Overpayments

If Blue Cross Blue Shield issues a benefit payment, either to you or your provider, that exceeds the benefit amount you were entitled to, Blue Cross Blue Shield has the right to collect the overpayment from you or your provider. The process Blue Cross Blue Shield will follow in collecting overpayments includes:

- Sending written request to be refunded, or
- Reducing the amount of the overpayment from future benefit payments.

Tips for Filing Claims

When you participate in Prime Choice or Standard Choice and you have a Network medical expense, the Network doctor, hospital or other provider is required to file the claim for you in accordance with the provider's Network participation agreement with Blue Cross Blue Shield.

Regardless of which medical plan you're enrolled in – Prime, Standard, Basic or Blue Choice HMO – mental health and substance abuse treatment providers who are participating in the Value Behavioral Health Network will file claims to VBH.

When you go to a provider that does not belong to the Network — or you participate in Basic Choice — you may have to file the claim yourself. If your doctor gives you an itemized bill, you should submit the bill attached to a claim form.

For prescription drug benefits, you must file a separate Blue Rx Drug Claim Form.

Medical and Drug Claim Forms may be obtained from the following sources: on-site via the electronic file server (using OSR numbers), SRS Stores or Blue Cross Blue Shield of SC Customer Service (1-800-325-6596).

- Medical Benefits Claim Form: SRS Stores 26-8120.00; OSR 5-340
- Blue Rx Drug Claim Form: SRS Stores 26-8122.00; OSR 5-341

A Claim Form for Mental Health/Substance Abuse Treatment may be obtained from VBH (1-800-333-6557) or by contacting Benefits Administration.

File claims promptly so you don't lose track of expenses. Remember, if you don't file a claim within the specified time limit after you incurred a medical expense (that is, within 15 months from the date of service or within one year from the end of the Plan Year, whichever is later), it will not be covered by your Health Choice medical option. You should "cluster" the bills for each individual family member onto a separate claim form, and then put the bills in order by type of service and date. If you are coordinating benefits with another plan that is primary (such as your spouse's employer's medical insurance plan that pays first), attach a copy of the other plan's Explanation of Benefits statement to the *claim form*. Keep a copy for your records — the claim form and all attachments — of the documents you send.

Submit the claim forms to the appropriate claims administrator:

Medical Claims
Blue Cross Blue Shield of SC
Claims Processing Center
P.O. Box 100300
Columbia, South Carolina
29202

Prescription Drug Claims
Blue Cross Blue Shield of SC
P.O. Box 711
Parsippany, New Jersey
07054

Mental Health & Substance Abuse Claims
Value Behavioral Health
P.O. Box 1008
Skokie, Illinois
60076

After your claim is processed, review your Explanation of Benefits (EOB) statement to make certain you've received the correct benefits.

If your benefits don't appear to be paid correctly, call the appropriate Customer Service Line and discuss the claim payment. Additional documentation may be required...if so, provide it promptly.

If you are not satisfied with the Customer Service response or believe that the claim was incorrectly paid or denied, you should file a written appeal to the appropriate claims administrator. An appeal must be made within 60 days after the claim was denied. An appeal is a written letter that provides the following:

— The claim number involved or a copy of the Explanation of Benefits statement,
— A copy of the Plan provision you feel was misinterpreted or inaccurately applied,
— Additional information from your doctor or other health care provider that will assist in completing the review of your appeal.

The claims administrator will review your appeal and notify you in writing of their decision, as well as the reason for the decision, with reference to specific Plan provisions.

If, after you have exhausted the above administrative steps, you still believe the claim was incorrectly paid or denied, a formal ERISA (defined on page 48) appeal for a review of the denied claim should be made to:

Plan Administrator
Benefits Administration
Westinghouse Savannah River Company
Building 730-1B, Mail Stop 12
Savannah River Site
Aiken, SC 29808

Your request must be submitted within 60 days of the date your appeal was denied by the claims administrator. It should include all documents, records, questions or comments necessary for a complete review, including reference to the specific Plan provisions that you feel were misinterpreted or inaccurately applied.

For more information about the Plan Administrator's authority for interpreting Plan provisions and how to file a formal ERISA appeal, refer to the Claims and Appeals Section in the General Information book.

Coverage Continuation in Special Situations

If you are involuntarily laid off from the WSRC Team and are a full-service employee, you may elect to receive Section 3161 extended medical benefits as provided under the National Defense Authorization Act federal workforce restructuring initiatives, if available at the time you are involuntarily laid off.

If you terminate your employment with the WSRC Team, coverage for you and your dependents will end on the last day of the pay period in which you are a full-service employee. You may be able to continue your coverage by electing COBRA continuation coverage or by converting to an individual "conversion coverage" policy. See information on page 42, and in the General Information book.

If you die, coverage for your dependents will end on the last day of the pay period in which you die, unless they are eligible to receive survivor benefits under the provisions of the WSRC/BSRI Pension Plan and pay the required monthly contribution. However, to continue receiving medical benefits, survivors must also meet the definition of "Eligible Dependents" on page 2. For example, parents and stepparents are not eligible for Health Choice survivor coverage. Also, if your surviving spouse remarries, the new spouse and his/her children cannot be added to your survivor's Health Choice coverage. (Note that a dependent child will no longer be covered by the WSRC/BSRI medical options upon reaching age 20, unless he/she is a full-time student at an accredited institution in which case medical coverage will continue until the child's survivor pension benefit ceases at age 21.)

If survivor benefits do not apply, your dependents will be eligible to continue their coverage by electing COBRA continuation coverage or by converting to an individual "conversion coverage" policy (see page 42). However, if your death is a result of an occupational injury or illness while you are a full-service employee of the WSRC Team or while receiving Special Benefits for Occupational Related Disabilities under the Disability Income Plan, medical coverage may be continued for your survivors as outlined above. Your survivors will be notified of the option(s) available.

If you retire under the Normal, Voluntary, Optional or Incapability provisions of the WSRC/BSRI Pension Plan, you will be eligible to continue medical coverage for yourself and your eligible dependents. If you elect coverage for yourself (and your eligible dependents if you desire to cover them), you will be required to pay the applicable monthly premium contribution. When you are about to reach age 65, you will have to apply for Medicare. Coverage for your dependent children will continue in effect as long as they continue to be eligible dependents as outlined on page 2 and you elect to cover them.

If you become totally and permanently disabled, you will be eligible for WSRC/BSRI medical coverage for up to 24 months in lieu of COBRA continuation coverage. At the end of this maximum 24-month period, your medical coverage ends; however, you may then become eligible for Medicare.

If you are on a paid leave of absence, your Health Choice medical coverage for yourself and your dependents will continue as if you were actively at work.

If you are on an approved Unpaid Leave of Absence (Unpaid LOA) such as a Family and Medical Leave, you will be able to continue your Health Choice medical coverage for yourself and your dependents, if you elected to cover them, as long as you pay the required monthly premium contribution in advance. When you return from the Unpaid LOA as an active employee, your premium contributions will resume on a pre-tax deduction basis from your WSRC Team paycheck. Before your Unpaid LOA begins, be sure to contact Benefits Administration for additional information and instructions on making the required premium contributions.

If, while on an Unpaid LOA, you should fail to make your premium payments in a timely manner (that is, by no later than 31 days after the beginning of the month), your Health Choice medical coverage for you and your dependents will be terminated retroactively to the beginning of the month for which the premium contribution was not made. When you return as an active employee from the Unpaid LOA, the Health Choice medical coverage that you had just prior to the Unpaid LOA will resume, with premium contributions deducted on a pre-tax basis from your WRSC Team paycheck. However, you and your dependents would have forfeited Health Choice medical coverage during the period of time that you did not pay the required premium contributions. Medical claims incurred by you or your dependents during that uncovered period of time will not be paid by the WSRC Team.

COBRA Continuation Coverage

Under federal law — the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA) — you and your eligible dependents may be entitled to continue your medical coverage for up to 18, 29, or 36 months depending on the reason for loss of coverage. Subsequent qualifying events also will determine the length of COBRA coverage. In order to be eligible for COBRA continuation coverage, you or your eligible dependents must have lost coverage under certain circumstances (such as termination of employment, divorce or death). In a divorce situation, Benefits Administration must be notified within 60 days after the effective date of the final divorce decree, or COBRA continuation coverage cannot be offered to your dependents. For more information on continuing coverage under COBRA, see the General Information book.

HIPAA Coverage

The WSRC/BSRI Health Choice medical options do not deny coverage to employees or retirees because of preexisting conditions. However, should you leave the WSRC

Team and go to work for another company, your coverage could be affected by restrictions on pre-existing conditions.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) limits the circumstances under which coverage may be excluded for medical conditions present before you enroll. Under the new law, a pre-existing condition exclusion in another company's coverage generally may not be imposed for more than 12 months (18 months for a late enrollee). The exclusion period is reduced by the amount of time covered under the WSRC/BSRI Health Choice Medical Plan. You are entitled to a certificate (automatically provided to you by WSRC) that will show evidence of your prior health coverage under the WSRC/BSRI Health Choice Medical Options, including the beginning and ending dates of your medical, dental and vision coverages. You should provide this certificate to your new employer.

If you buy health insurance other than through an employer group plan, the WSRC certificate of prior coverage may help you obtain coverage without a preexisting condition clause.

Conversion Privilege

If you do not wish to continue Health Choice medical coverage under COBRA, you may apply for an individual "conversion coverage" policy without medical examination. Application for an individual policy must be made to Blue Cross Blue Shield within 30 days after the termination of your WSRC/BSRI Health Choice medical coverage. Contact Benefits Administration for an application.

If you elect COBRA continuation coverage, you may request conversion to an individual "conversion coverage" policy within 30 days of the expiration of your COBRA continuation coverage period.

Network Treatment Disclaimer

Neither Blue Cross Blue Shield, Value Behavioral Health (VBH) nor the WSRC Team is responsible in any way for treatment received from the providers who participate in their respective Networks. While Blue Cross Blue Shield and VBH administer their Networks and make every attempt to evaluate the doctors and other health care providers against credentialing standards, no guarantees are made as to the competency of the providers or the quality of the treatment and services. Any malpractice issues on the part of the patient or family must be solely directed at the specific provider(s) of the treatment or service.

Glossary of Helpful Terms

Understanding what your medical benefits are and how they work is an important part of becoming an informed health care consumer. This book contains many medical terms...some will be familiar to you, others may not. Here is a handy reference list:

Acute

A rapid, sudden and unexpected onset of a change in a person's physical or mental condition, necessitating immediate medical attention.

Coinsurance

The percentage you pay for covered services (except Network doctors' office visits with copays of $10 or $20 under Prime Choice and Standard Choice). Your coinsurance amounts for most medical services are 10%, 20% or 30%, depending on the Health Choice medical option you choose and the provider you use.

Copay

The flat dollar amount ($10 or $20) that you pay — under Prime Choice or Standard Choice — when you receive treatment in a Medical Network doctor's office. The medical options pay the balance of the cost of the office visit for most services. Also, the copay applies to office services, such as a laboratory test with or without a physical examination by the physician.

Deductible

The initial amount of medical expenses you are responsible for each year before Prime Choice or Standard Choice pays benefits for non-Network services (such as prescriptions) and before Basic Choice pays for almost all services. You must pay a new deductible each year...there is no carryover from one year to the next. A separate $250.00 annual deductible is required for inpatient mental health services and/or inpatient or outpatient chemical dependency treatment services.

Durable Medical Equipment

This is equipment that is:

- Made to withstand prolonged use;
- Made for and mainly used in the treatment of a disease or injury;
- Suited for use in the home;
- Not normally of use to persons who do not have a disease or injury;
- Not for use in altering air quality or temperature; and
- Not for exercise or training.

Emergency Care

An injury or illness so severe or acute that it could cause death or permanent damage. It is an unforeseen condition of such acute nature that failure to receive immediate care or treatment could result in deterioration to the point of placing the person's life in jeopardy or causing significant impairment to bodily functions. *(Some examples: a severed artery; an asthma attack.)*

Experimental

A drug, device, procedure or treatment will be determined to be experimental or investigational if in the judgement of the Claims Administrator:

- There are insufficient outcome data available from controlled clinical trials published in peer-reviewed literature to substantiate its safety and effectiveness for the disease or injury involved;
- Required by the Food and Drug Administration (FDA), its approval has not been granted for marketing;
- A recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental, investigational or for research purposes; or
- The written protocols or informed consent used by the treating facility or another facility substantially studying the same drug, device, procedure or treatment, states that it is experimental, investigational or for research purposes.

Extended Care Facility

A facility which provides 24-hour-a-day nursing care by RNs and/or LPNs and is accredited by the Joint Commission on Accreditation of Health Care Organizations or is recognized (certified) by Medicare.

Home Health Care Agency

An organization that is specially licensed to provide certain nursing and other health care services to individuals who require in-home care.

Hospital

An acute care facility where patients with serious illnesses or injuries can receive extensive diagnostic and treatment services on an inpatient or outpatient basis. Not a convalescent facility, nursing home, or facility for the aged.

Inpatient Services

Services that are provided as a bed patient in a hospital, a rehabilitation hospital, an extended care facility (skilled nursing facility), or a substance abuse treatment facility.

Life-Threatening

Any condition, illness or injury that if left untreated would result in:

- Loss of life or limb;
- Significant impairment to bodily function; or
- Permanent dysfunction of a body part.

Medical Necessity

Requirement that services or medical supplies must be considered appropriate, in the opinion of Blue Cross Blue Shield, to diagnose or treat a covered person's illness or injury. To be appropriate, the service or supply must:

- Be care or treatment likely to produce a significant positive outcome, and no more likely to produce a negative outcome than any alternative service or supply, both as to the disease or injury involved and the person's overall health condition; or
- Be a diagnostic procedure, indicated by the health status of the person and be as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the person's overall health condition; and
- As to diagnosis, care and treatment, be no more costly (taking into account all health care expenses incurred in connection with the service or supply) than any alternative service or supply to meet the above tests.

Network

A group of doctors and other health care providers who contractually agree to undergo an extensive screening process and provide care at pre-negotiated discounted rates. Blue Cross Blue Shield administers the medical Network; Value Behavioral Health administers the mental health and substance abuse treatment Network.

Network Provider Directory

The booklet containing a listing of doctors, specialists and hospitals that participate in the Blue Cross Blue Shield Medical Network. The Network administered by Value Behavioral Health is unpublished.

Out-of-Pocket Maximum

The most you will pay in deductibles and coinsurance for covered expenses during any one calendar year before your Health Choice Medical option begins to pay 100% of eligible covered expenses. Certain expenses — such as the copay ($10 or $20), costs that exceed R&C, and pre-admission certification penalties — do not count toward the out-of-pocket maximum. Refer to the lists on pages 10 and 11.

Outpatient Services

Services provided outside a hospital-confined setting. This includes services provided in the outpatient department of a hospital, a clinic, or a doctor's office.

Premium Contributions

The amount you pay to purchase medical coverage (not what you pay when you use the coverage). Active employee premium contributions are paid with before-tax dollars and are deducted from your paycheck...monthly or weekly...depending on your pay frequency. Other mechanisms exist for payment of premium contributions by persons who are not active employees.

Reasonable & Customary (R&C)

The basis for payment of treatment and services received from a non-Network provider —when you participate in Prime or Standard Choice — and for treatment and services received under Basic Choice. R&C charges are determined by taking into account:

- The normal range of fees charged by providers in your geographic area for similar services, and
- Any unusual circumstances.

Routine Care

An injury or illness that can be treated or managed adequately at home until you can arrange to see your family doctor (for example, a cold). Routine care also encompasses most preventive care which must be received by Network providers or benefits will be denied.

Treatment Center for Chemical Dependency

A facility that is approved by Value Behavioral Health, and is staffed and equipped to provide specialized treatment of alcoholism and narcotics addiction.

Urgent Care

Treatment for an acute injury or illness that is not life-threatening, but requires immediate medical attention to minimize severity and prevent complications (for example: a broken bone, food poisoning).

ERISA Information

As a participant in the WSRC/BSRI Health Choice Medical Plan, you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 as amended (ERISA). The official documents which govern the medical options dictate the actual operation of the Plan and the payment of benefits. For more information on your ERISA rights and administration of the Plan, refer to the General Information book.

Plan Information

Type of plan: A self-insured welfare plan that provides health benefits

Plan Name: Health Choice Medical Plan (Prime Choice, Standard Choice and Basic Choice)

Plan Sponsor: Westinghouse Savannah River Company and Bechtel Savannah River, Incorporated (WSRC/BSRI)

Employer Identification Numbers of The WSRC Team:
Westinghouse Savannah River Company (WSRC).....25-1575269
Bechtel Savannah River, Incorporated (BSRI).....94-3077224
Babcock and Wilcox Savannah River Company (B&W).....54-1804131
British Nuclear Fuels, Limited, Savannah River Corporation (BNFL).....54-1813446

Plan Number: 501

Plan Year: January 1 - December 31

Plan Administrator:
Benefits Administration
Westinghouse Savannah River Company
Building 730-1B, Mail Stop 12
Savannah River Site,
Aiken, South Carolina 29808

Claims Administrators:
Blue Cross and Blue Shield of South Carolina
I-20 at Alpine Road
Columbia, South Carolina 29219

Value Behavioral Health (mental health and substance abuse treatment benefits only)
Attn: WSRC Administrator
Suite 1100
4709 Golf Road
Skokie, Illinois 60076

Agent for Legal Process:
CT Corporation System
75 Beattie Place
Greenville, SC 29601

Eligibility for benefits should not be viewed as a guarantee of employment. Also, while WSRC/BSRI intends to continue providing a comprehensive benefits program, WSRC/BSRI reserves the right to modify or terminate any of the benefit plans at any time. For more information on the procedures to modify or terminate benefit plans, refor to the General Information book.